

Ohmann-Dumesnil (A. H.)

Reprinted from THE TRI-STATE MEDICAL JOURNAL, St. Louis, Mo., February, 1896.

RUPIA.

By A. H. OHMANN-DUMESNIL,

Professor of Dermatology and Syphilology in the Marion-Sims College of Medicine,
St. Louis.

TO the serious student of medicine, there is no more interesting department than syphilology. The study of the various processes which are found in syphilis, is one which is always interesting, and it is withal of the highest utility in arriving at a correct diagnosis, and in formulating a successful plan of treatment. Many visceral diseases of an apparently obscure origin, and intractable to treatment, readily yield the most brilliant results when properly traced to their true origin—syphilis. It should always be borne in mind that this trouble may be a possible factor, for it is so widely disseminated, and, in many instances, its earlier stages are of such a mild character that the patient has either forgotten the circumstances, or looks upon the whole affair as of such a trivial nature that he does not look upon it as incumbent on him to make any mention of it. In addition to this, the generality of the medical profession have paid but comparatively little attention to the subject, and unless confronted by an eruption often forget the fact that lues is a protean disease in its manifestations, and one requiring more than perfunctory treatment. It should be watched with care, and not, as too frequently happens, be met with neglect. And even eruptions are but too often mistaken for syphilitic when not so, and vice versa. Among the eruptions which are very apt to lead to error are those of the late period of syphilis. So-called tertiary syphilis is but too often supposed to be confined to gummata and affections of the bones when, in reality, it is replete with various eruptions of a most interesting nature.

I do not intend entering into any lengthy dissertation upon syphilis and its nature and different manifestations as the subject is practically an inexhaustible one. But, it may not be inappropriate to call attention to the fact that syphilis is by no means a disease which has remained *in statu quo*. As a matter of fact, it has become a comparatively mild disease, if we are to place any reliance on history. In the fifteenth century it was most virulent, and deaths were by no means uncommon, and they followed infection in an incredibly short space of time. This virulence abated gradually, but no later than fifty years ago we find descriptions and plates of the disease representing it as much more severe than we are accustomed to find it to-day. However, we occasionally have occasion to observe cases which recall some of the older types, which have apparently disappeared. It is chiefly in neglected, imperfectly treated or generally depraved physical conditions that such reversals of type are met with, and they are of such a nature as to be markedly debilitating and rapidly destructive in their action.

Rupia may be stated to be, in general terms, one of the cutaneous



lesions characteristic of late syphilis. On the other hand, like other manifestations of this character it may appear comparatively early, and in precocious cases it is sometimes seen in the course of the first year of the trouble. As a matter of fact, it is essentially a modification of the pustulo-crustaceous syphilide, the changed appearance being largely dependent upon the lowered state of the tissues of the individual. The evolution of the individual lesions is a slow one, and both progressive and destructive. To recognize it before its full development is impossible; to prevent its evolution is comparatively an easy matter. The first manifestation which is observed is in the form of a dark red macule, which gives rise to little or no anxiety on the part of the patient, whilst the color has been described as copper-colored, cut-ham in tint, to my mind it is more of a red, slightly tinged with brown, nearly approaching a sepia on a red ground. This macule is succeeded by a small flat pustule, whose innocent appearance is very deceptive. It is, however, soon covered by a greenish-brown crust, which is never very large, possibly a quarter of an inch in diameter, and roundish or slightly ovalish in outline. A peculiarity of the crust is that it has quite a marked tendency to become thick, and this thickening increases as the disease progresses. The first appearance of the crust is not of a particularly alarming character, as it is not excessively thick and, at its inception, ordinarily gives rise to little or no suspicion of its true nature, unless in the mind of one well acquainted with it.

Rupia, whose name is derived from *rupos* (dirt), is, in reality a superimposition of a series of dirty, greenish-brown or blackish-red crusts upon each other, and resting upon an ulcerated base, covered with a greenish-yellow, foul-smelling pus, occasionally streaked with blood or containing small portions of clotted blood. Directly a crust has formed and obtained a certain size (generally a quarter of an inch or so in diameter), another crust forms immediately underneath the first, of the same general outline, but a little larger in area. This process, it must be understood, does not imply that the first crust is thin—on the contrary, it is thick and may be conical in form, its height being fully equal to the diameter of its base. The successive formation of crusts immediately underneath each other goes on steadily and rather slowly, and, as already mentioned, each one is larger than its predecessor, and the underlying ulceration becomes deeper. The process may go on for an indefinite period of time, and the crusts will remain as a whole, being rather firmly attached to the underlying tissues. It may be stated, as a general fact, that in an untreated case, the accumulation of crusts has notably increased the height of the lesion, the area of its base has become larger, and the underlying ulceration has become deeper with each successive lamination. Another point not to forget is that this progressive ulceration introduces the element of pain, and this increases *pari passu* with the extension of the process.

Of course, this element of pain is only manifested upon pressure on the lesion.

When a rupial crust is closely examined, it will be found that it is surrounded by a narrow band of pus, giving the impression that it is floating.

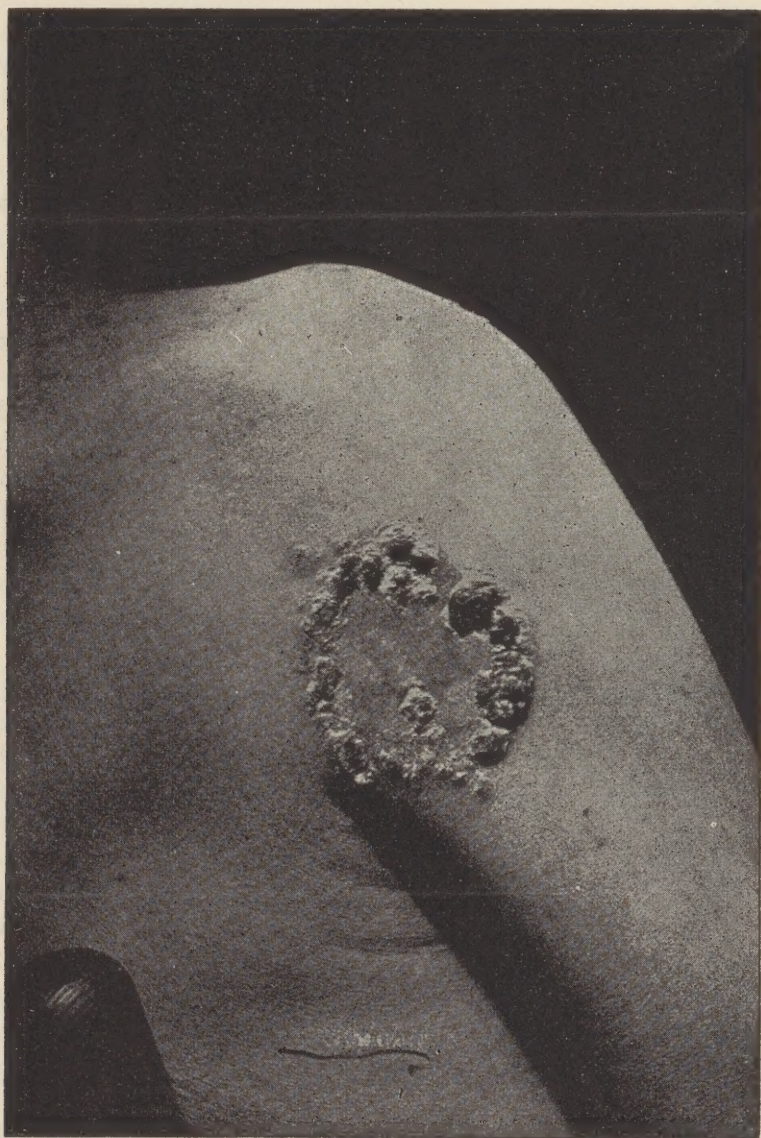


FIG. 1. Small Crusts of Rupia.

External to this purulent zone there is an areola, more or less pronounced, of a dusky copper-red color, which gradually merges into the color of the normal integument. When the lesion has disappeared, the characteristic

pigmentation is manifest in the scar, which marks the former site of the crust. The number of rupial crusts which may be observed in a case varies greatly. A peculiar fact which is noted is that, in some individuals, the crusts remain comparatively small in size, and never exceed a half inch in

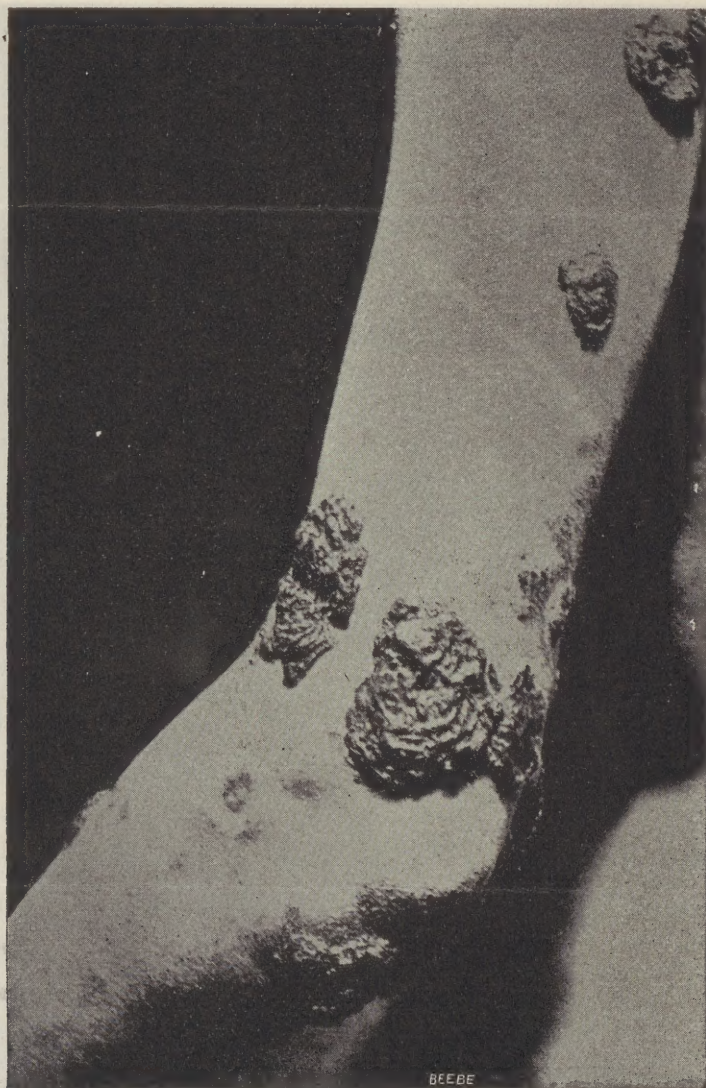


FIG. 2. Large Crusts of Rupia.

diameter. A good example of this may be seen in Figure 1. Here it will be seen that an attempt at confluence has declared itself, but never succeeded in becoming established. On the other hand, the size of the individual lesions is made up by their number. For, in this, as in all other cutaneous

involvements, the rule holds that the smaller the lesions, the greater the number, and vice versa. Rupial crusts may attain a size much larger than these just mentioned, and be as much as two inches in diameter, and as thick as an inch or more, with a more or less imperfect conical form. It is when they have attained this large size that rupial crusts present their characteristic form. It is then that we encounter the so-called "oyster-shell" appearance which is very well shown in Figure 2. As may be observed in this picture, the rupial eruption is in various stages, a circumstance which is not unusual in such cases. The various sizes and degrees of evolution are quite typical of the successive manner of their appearance. The mode of growth by superimposition of crusts is also well shown in the largest lesion.

It is true that rupia, even in its milder forms, is but infrequently seen in private practice. The most marked cases and the severer forms, are those met with in public hospitals, clinics and eleemosynary institutions. This is no doubt dependent upon the fact that those who are the carriers of such lesions are individuals who have been debilitated by exposure, lack of food, excessive drinking and deficiency of treatment. Filth and carelessness also add their quota to this general physical ruin and general break-down. Typical cases, however, are far from being rare in public hospitals, in both males and females, and constitute marked examples of the types of wretchedness, poverty and degradation which the shady quarters of large cities furnish.

It may be laid down, as a general rule, that the lower extremities are not the seat of rupia. It seems to have a predilection for the arms and face, the trunk not being often attacked, and then it is the back which most frequently suffers. At least, such has been my experience. When the legs do become the seat of rupia, it is almost always certain that other portions have been affected. When the face becomes affected the crusts may be so thick as to make the physiognomy perfectly hideous, or if but one side is affected, sufficiently ugly to be repulsive as may be seen from an example in Figure 3. It is when lesions assume the size and proportions delineated in the accompanying figures that terror seizes upon the patient, and leads him to seek treatment. The crusts of rupia differ somewhat from the earlier syphilides in that they do not assume any symmetrical distribution. Unilateral disposal seems to be the rule, and the reason of this does not seem to be apparent. A strange coincidence which may be noted in the figures which accompany this article, is that the crusts appear on the left side.

The natural termination of an untreated case of rupia is in one of two ways. In some cases the crusts drop off spontaneously and, in the course of time, and cicatrization finally occurs the scars being rather thick and corded and in many cases cribriform, that is, showing the perforations of the ducts of the sebaceous glands as well as sweat-pores. In other cases, the ulcerative process may take on a sudden impulse, and become deeper and deeper.

This naturally leads to greater or less destruction, and a deep ulcer will ultimately manifest itself which will go deep down into the tissues to the extent of even involving the underlying bony structures. This is certainly a serious matter, and the fact, such may be the final outcome of any case of rupia, should not only lead to the adoption of active curative measures, but should make a prognosis guarded; whilst proper care and attention to both nutritive and medicinal requirements are generally followed by excellent results, cases will arise which seem to stubbornly resist all measures.

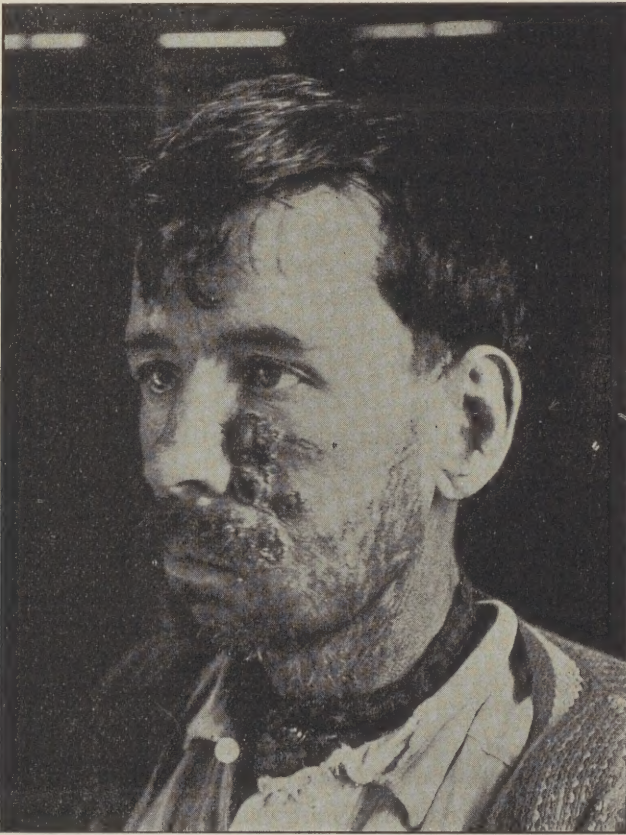


FIG. 3. Confluent Rupial Crusts of the Face.

The diagnosis of this trouble should offer no difficulties whatever as there is no cutaneous affection which possesses lesions having the same characteristics as rupia. The peculiar form and progressive growth of the crusts as well as their dirty reddish-brown color should immediately awaken suspicions of its true character. The marked fetid odor is also a sign which is almost pathognomonic if it has been once experienced by the nostrils. The generally run-down condition and appearance are further confirmatory elements to form a diagnosis not to mention a history of syphilis which can always be obtained in such cases.

Whilst the general broad lines of treatment may be easily laid down, it requires a certain amount of judgment to properly carry out the necessary details to obtain a successful issue. In the first place it is absolutely essential that good, nutritious food in sufficient quantity should be eaten by the patient. His surroundings should be clean and comfortable. If necessary to countereffect the stimulating effects of the alcoholics which have been previously taken, kola wine combined with bitter vegetable tonics should be administered. These will be found to be the best adjuvants to the more specific remedies which are given. So far as specific medication is concerned, it will be found that an active mixed treatment is the best to begin with. This is more especially valuable in those cases which are in the transition period between the secondary and tertiary periods. The following will be found quite an effective combination to use:

R Hydrargyri bichloridi,	gr. ij.
Kali iodidi,	℥ ij.
Tinct. cinchonæ co.,	
Aquæ destillatæ,	aa ℥ iv.

M.

Sig. Half a tablespoonful in milk, after each meal.

In some instances, it will be found necessary to diminish the quantity of mercury, or to stop it altogether, keeping up the same dose of iodide of potassium. It should not be forgotten to administer the iodide in milk, in order to avoid any irritation of the gastric mucous membrane. Furthermore, it will be found that the administration of teaspoonful doses of bicarbonate of soda in water (preferably ærated) between meals, or better two hours after each meal will prevent iodic intoxication. The size of the dose of iodide of potassium must be governed entirely by each individual case, and its effects should be carefully watched in order to determine this point accurately.

The local treatment of rupia is of no small importance. To begin with, the crust should be removed, preferably with a bichloride poultice of a strength of about 1 in 1000. After this the floor of the ulcer, which is then exposed, should be cleansed with a 1 to 500 solution of bichloride. If the granulations be unhealthy in appearance, large and flabby, the walls of the ulcer everted and undermined, a good curetting will be of benefit. If the granulations appear sluggish, they should be stimulated with a solution of acid nitrate of mercury, one drachm to the ounce, lightly pencilled over the surface. If the granulations become too exuberant, they should be repressed, and for this purpose, there is no better means than by means of the caustic method. This is done by passing over the granulations a small, smooth, soft-pine paddle which has been dipped in nitric acid, c. p. This will not only repress the granulations, but will also act as a stimulant, and prevent the ulcerative process from extending any deeper. In any event, the best dressing to use is a bichloride gauze dressing which should be renewed daily. The gauze should be saturated with a one to one thousand solution of bichloride, and *not* covered with an impermeable dressing. A much better plan is to have the patient keep the gauze moist by occasionally dropping on some of the solution. If the ulcer takes on a good action, the dressing may consist of campho-phénique powder, which will form an artificial crust and lead to complete healing underneath it.

A careful attention to details and cleanliness is absolutely necessary. It may be found necessary to permit periods of rest in the course of the internal treatment, but it must never be forgotten that eternal vigilance is the price of a successful issue in every case of rupia.

